HISTORY AND PHYSICAL

Name ______________________ S.S.# ______________________ Date ______________________

Phone (Home) ______________________ (Work) ______________________ Birth Date ______________________

DRUG ALLERGIES

____

CURRENT MEDS

____

____

____

____

HOSPITALIZATION OR SURGERY

Reason	Date

FAMILY HISTORY

	YOURSELF	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Heart Disease							
High Blood Pressure							
Stroke							
Cancer							
Colon CA/Polyps							
Glaucoma							
Diabetes							
Epilepsy/Convulsions							
Bleeding Disorder							
Kidney Disease							
Thyroid Disease							
Mental Illness							
Ulcer							
Liver Disease							
Alcoholism							
Arthritis							
COPD/Asthma							

PAST MEDICAL HISTORY

- ❒ Headaches ______
- ❒ Shortness of breath ______
- ❒ Heart palpitations ______
- ❒ Heart murmur ______
- ❒ Arrythmias ______
- ❒ M.I's. ______
- ❒ CHF ______
- ❒ High cholesterol ______
- ❒ Chest pain ______
- ❒ Dizziness/Fainting ______
- ❒ Peripheral vascular disease ______
- ❒ Allergies/Hay fever ______
- ❒ Endocrine disease ______
- ❒ Bronchitis ______
- ❒ Pneumonia ______
- ❒ Lactose intolerance ______
- ❒ Gall bladder disease ______
- ❒ Prostate disease ______
- ❒ Bowel irregularity ______
- ❒ Bladder/Urinary problems ______
- ❒ Sexual/Menstrual dysfunction ______
- ❒ Sexually transmitted disease ______
- ❒ Frequent infections ______
- ❒ Hepatitis ______
- ❒ Anemia ______
- ❒ Back/Joint pain ______
- ❒ Osteoporosis ______
- ❒ Nervousness ______
- ❒ Anxiety/Fatigue ______
- ❒ GI disorder ______
- ❒ Depression ______
- ❒ Gout ______
- ❒ Scarlet fever ______
- ❒ Chronic rashes ______
- ❒ Rheumatic fever ______
- ❒ Mumps ______
- ❒ Measles ______
- ❒ Rubella ______
- ❒ Polio ______
- ❒ Diphtheria ______
- ❒ Tetanus ______
- ❒ ______
- ❒ ______
- ❒ ______
- ❒ ______

WOMEN ONLY

Pregnant? ❒ Yes ❒ No Planning Pregnancy? ❒Yes ❒ No Complications? ❒ Yes ❒ No

HABITS

- ❒ Smoke:Packs Daily ______ How Long ______ When Stopped ______
- ❒ Exercise Routine ______ ❒ Coffee: Daily Cups ______ Other Caffeines ______
- ❒ Alcohol: Type/Amount ______ ❒ Sleep Pattern ______ ❒ Diet: Salt ______